CT 5281

Mr. Chairman/Madam Chair, members of the committee, for the record my name is Robin Kingston with Emdeon and I would also like to testify in support of Bill 5281.

- The Bill before you contemplates random sample audits of Billing and suspension of licensure for perpetrators of fraud and purposeful aberrant billing.
    - As mentioned in my previous testimony, auditing of billing and supporting medical documentation is a key and necessary tool to help combat fraud, waste and abuse with an savings as high as 3-7% of the total medical spend.
        - Based on CT's total Medical Assistance spend of $6B, a 15% sample audit and recovery program could yield savings well into double-digit millions.

- As a nationwide leader in health care fraud, waste & abuse detection & prevention with over 25 years of experience in the field, Emdeon recommends the state act on this Bill now, but also consider going further.
- In an era of
    - budget constraints and
    - pending increases projected in Medicaid enrollment under the Affordable Care Act,
    - it has never been more important to utilize multiple, proven safety nets to increase ability to detect and prevent fraud, waste & abuse.
- Under Section 6028 of the Affordable Care Act, the State will have to comply with specific fraud, waste and detection measures by 2014. We would recommend the state consider:
    - Enacting these provisions prior to 2014 in order to achieve the savings sooner, and
    - Verify that the state regulations allow for the use of the savings generated from the tools to cover the cost of the programs – to eliminate the need for separate budget line-item allocations.

- These provisions would include:
    1. Shifts from a pay-and-chase model to a preventive, pre-payment model of detection.
    2. In-stream PV validation – on claim-by-claim, basis to ensure providers are not sanctioned or have license suspensions in any state & are not deceased – this complements the existing provisions of this Bill nicely
    3. Predictive Modeling: use of data mining techniques that employs the power of the data itself to elevate aberrance of schemes & scams we do not know to look for today – vs. today's environment of rules-based systems where we know to look for only what we know to look for...and those perpetrating fraud are constantly evolving and developing new means and methods to fraud.

- Like the Corrections Bill, it is important to note that these measures would not:
    - impact or delay the delivery of care to patients in any way, as all tools are utilized to assess claim data, which is submitted for payment as it is today...*after* services are rendered.
    - Or, delay payment of legitimate reimbursements to providers, as all electronic validations and scoring of claims happens within hours...24 hours at most...of the receipt of claims

- National statistics for FWA savings range from ½ - 3% of total spend for a comprehensive, proactive program
    - That would mean additional potential millions in savings

- These measure could also help to pre-empt other, more drastic measures elsewhere to deal with budget constraints:
    - Reduction of benefits to beneficiaries
    - Reduction of provider reimbursement schedules...which negatively impact *all* providers, the vast majority of which are acting in good faith and providing quality care to those most in need.

- The risk in not acting could be significant, as FWA act as a balloon – stories are abundant of fraud taking advantage of public systems as private insurers have tightened controls & we expect to see further shifting among states and the Medicare system as tools are deployed in some areas and not in others.

- While there is no single magic bullet to eliminate FWA, adoption of the measures in this Bill will keep MD on the leading edge of this fight nationwide.

I would be happy to answer any questions you may have.